PRINTED: 09/07/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G635	(X2) MU A. BUILI B. WING	DING	ONSTRUCTION 00	CO	ATE SURVEY MPLETED /23/2012
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP	CODE	
ARC OF	NORTHWEST IND	DIANA INC, THE			(NOX ST IN 46403		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0000							
			W00	00			
	This visit was fo	or an extended					
	recertification a	nd state licensure survey.					
	Dates of survey	: July 16, 17, 19, 20, and					
	23, 2012						
	,						
	Facility number	001211					
	Provider numbe						
	AIM number: 1						
	Alivi liuliloci.	100244030					
	Surveyor: Chris Surveyor III/QN	stine Colon, Medical MRP					
	reflect state find 460 IAC 9.	rederal deficiencies also dings in accordance with					
	Shackenord, iviedit	cai Sulveyoi III.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

001211

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII DING	00	COMPLETED
		15G635	A. BUILDING B. WING		07/23/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	PROVIDER OR SUPPLIE	ER			
ABC OF	NORTHWEST INI	DIANA INC. THE		KNOX ST IN 46403	
ARC OF	NORTHWEST IN	DIANA INC, THE	GART,	111 40403	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W0122	483.420				
	CLIENT PROTE				
	The facility must ensure that specific client protections requirements are met.				
	Based on record	d review and interview, the	W0122	Community Services Nurse w	ill 08/22/2012
	Condition of Pa	articipation of Client		re-train DSP's on following ea	
		s not met as the facility		client's individual diets.To ens	
		plement their neglect		future compliance, Communit	-
	1 ~			Services Nurse will conduct a	
	1 2	lected for 1 of 2 sampled		observation at mealtime once	
	`	(2), to provide her		month for 3 months and quar thereafter. 8/28/12Service	terry
	prescribed special diet.			Coordinator and/or Communit	hv
				Services Nurse will retrain all	
	Findings includ	le:		for all medical supervision wit	
				regards to medical and dietar	<b>I</b>
	Please refer to	W149. The facility		needs for clients. Training forms	
		-		will be submitted to the Staff	
	"	plement their neglect		Development Department for	
	1	lected to provide adequate		tracking and filing. Staff will	
		1 of 2 sampled clients		document dietary restrictions	and
	(client #2), by 1	not providing her		food prepared on daily logs. Service Coordinator and/or	
	prescribed spec	eial diet.		Community Services Nurse w	ill I
				review the logs daily. To ensur	
	9-3-2(a)			future compliance, Service	
				Coordinator and/or Communi	ty
				Services Nurse will visit the g	
				home at least weekly for four	
				weeks and then at least	
				bi-monthly thereafter, the Ser	vice
				Coordinator and Community	
				Services Nurse will review log daily. All training forms will be	<b>′</b>
			submitted within 48 hours of a	<b>I</b>	
				training sessions to Staff	AII
				Development Department.	

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Event ID: V8G911

Facility ID: 001211

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		15G635	B. WINC			07/23/	2012
NAME OF D	DOVIDED OD GUDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			440 N K	NOX ST		
	NORTHWEST INDI			GARY,	IN 46403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)		IAG	DEFICIENCI)		DATE
TAG W0125	483.420(a)(3) PROTECTION Of The facility must of clients. Therefore and encourage in their rights as clie citizens of the Unright to file comple process.  Based on record 1 of 2 sampled conclient (clients #2 failed to ensure the obtaining a legal maker.  Findings include A review of client conducted at the office on 7/17/12 of client #2's "Conform" dated 3/12 assistance with a decisions." The Assessment date "Does not use more with all banking cannot be sent or errands and does Is unable to endoor print any work.	nt #2's record was facility's administrative 2 at 12:00 P.M Review conference Summary 1/11 indicated: "Needs making major life "Developmental ed 4/4/12 indicated: coneyrequires assistance budgeting needs. She in independent shopping into shopping at present. corse a check, cannot write ds, and does not read. inding of numbers. She is	W01	25	The Arc Northwest Indiana is currently assessing the criteria the NIAGS program to possibly obtain guardianship for client # The Service Coordinator will continue to monitor the proces and provide all necessary documentation to achieve this goal. 8/28/12The Arc Northwest Indiana is currently in the procof retraining an attorney to file guardianship papers for client and other clients in need of guardian by 10/1/12 with court date being scheduled 12/1/12.	ofor y \$3. s st ess	08/22/2012
	associate time on a clock with various						
	events. She has	no understanding of time					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G635			ULTIPLE CO LDING	ONSTRUCTION  00	(X3) DATE S COMPL 07/23/	ETED	
		100000	B. WIN		ADDRESS SITE STATE STATES	011231	2012
NAME OF I	PROVIDER OR SUPPLIEF	t .			ADDRESS, CITY, STATE, ZIP CODE  (NOX ST		
ARC OF	NORTHWEST IND	IANA INC, THE			IN 46403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	`			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	DATE
PREFIX TAG	intervals, equivalindividual Support 7/6/11 indicated SelfWill learn pointing to picture coinsWill learn medicationsIs receiving training the seconducted at the office on 7/17/12 "Developmental 3/30/12 indicate seeing. Unable wheelchair. Doe assistance with a budgeting needs shopping errand independent shout check, Cannot who where the seconducted at the office on 7/17/12 "Developmental 3/30/12 indicates seeing. Unable wheelchair. Doe assistance with a budgeting needs shopping errand independent should be to tell time on clock where the second intervals. No under the indicated: "Legal An interview with Coordinator (SC facility's administrat 12:50 P.M The second intervals are second interview with the second intervals are second intervals."	to better communicate by res. Will learn to sort in to recognize her own monverbal and is g in communication."  In #4's record was facility's administrative 2 at 11:50 A.M The Assessment" dated d: "Has some difficulty to walk and uses a resn't use money, requires all her banking and and and cannot be sent on and does no pping. Cannot endorse a rrite or print words. Is understanding of numbers, ne, does not associate at the various actions and restanding of time also dated 6/22/12 al Status: Self."		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE .	COMPLETION DATE
		to assist in making					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G635		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	— COM 07/2	E SURVEY PLETED 3/2012	
ARC OF	PROVIDER OR SUPPLIER	IANA INC, THE	440 N K	ADDRESS, CITY, STATE, ZIF KNOX ST IN 46403	PCODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR financial decisio	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ns and were not capable	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	of making finance independently.  9-3-2(a)	rial decisions				

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Event ID: V8G911

Facility ID: 001211

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING OO COMPLETI			ETED	
		15G635	B. WIN			07/23/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R			(NOX ST		
ARC OF	NORTHWEST IND	DIANA INC, THE			IN 46403		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0140	483.420(b)(1)(i) CLIENT FINANC The facility must system that assu accounting of clie entrusted to the Based upon rece the facility faile accounting syste residing at the g whom the facili funds.  Findings include A review of the reports was con P.M Review of Incident report of #3]'s money wa Tuesday night a by [Direct Supp #1] and [DSP #2	establish and maintain a ures a full and complete ents' personal funds facility on behalf of clients. Ord review and interview, d to maintain an accurate erm for 1 of 4 clients group home (client #3), for ty managed the client's	W0		Service Coordinator will retrain DSPs on timely completion an accuracy of client budgeting. A discrepancies will be reported Service Coordinator immediate To ensure future compliance Service Coordinator will review client budgets and accounts o bi-monthly basis and at least monthly thereafter.	d Any to ely. v	08/22/2012
	review of the re	0 missing." Further port indicated the funds					
	were missing to cash.	r client #3's personal petty					
	facility's admini at 12:45 P.M	ith the Service C) was conducted at the istrative office on 7/17/12 The SC indicated staff are rate accounting system of					

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	OF CORRECTION  OF CORRECTION  15G635	(X2) MULTIPLE CO  A. BUILDING  B. WING	00		TE SURVEY MPLETED 23/2012		
	PROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE  440 N KNOX ST  GARY, IN 46403					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE ACTI CROSS-REFERENCED TO DEFICIENC	ON SHOULD BE	(X5) COMPLETION DATE		
			CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE Y)			

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Event ID: V8G911

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	4 DI III	DDIC	00	COMPL	ETED
		15G635	A. BUII B. WIN	LDING		07/23/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				KNOX ST		
ADC OF I	NORTHWEST INDI	ANA INC. THE			IN 46403		
ARC OF I				GART,	IN 40403		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG DEFICIENCY)			DATE	
W0149							
	STAFF TREATMENT OF CLIENTS						
	•	develop and implement					
		nd procedures that prohibit					
	mistreatment, neg	glect or abuse of the client.	1170	1.40			00/02/2012
	Based on observation, record review and		W0	149	Client #2 had a cookie swallov	V	08/22/2012
					done on 7/26/12. The results		
	interview, the fac	cility neglected to			indicated client was to have nothing by mouth due to choki	na	
	implement their	neglect policy and			risk. A PEG tube was placed of	•	
	neglected to prov	vide adequate health care			8/5/12. Community Services		
	-	ed clients (client #2), who			Nurse will train DSPs on		
	needed a special diet.				necessary use and care of the		
needed a special diet.				PEG tube. To ensure future			
					compliance, Community Servi	•	
	Findings include	:			Nurse will make a mealtime vi	sit	
					monthly for 3 months and		
	A morning obser	vation was conducted at			quarterly thereafter.		
	the group home	on 7/16/12 from 6:15			8/28/12Service Coordinator and/or Community Services		
	• •	A.M During the			Nurse will retrain all staff for al	ı	
		ct Support Professional			medical supervision with regar		
		* *			to medical and dietary needs f		
		ed oatmeal, waffles and			clients. Training forms will be		
		At 7:20 A.M., client #2			submitted to the Staff		
	was observed ear	ting a bowl of oatmeal of			Development Department for		
	regular consisten	cy. At 7:25 A.M., client			tracking and filing. Staff will		
	#2 started cough:	ing repeatedly, had tears			document dietary restrictions a	and	
	•	aliva coming out of her			food prepared on daily logs.		
		walked from the kitchen			Service Coordinator and/or	11	
					Community Services Nurse wi review the logs daily. To ensure		
		of water on the table and			future compliance, Service	5	
	_	Irinking the water. Client			Coordinator and/or Community	,	
	#2 repeatedly coughed for about 10				Services Nurse will visit the gr		
	minutes.				home at least weekly for four	-	
					weeks and then at least		
	An interview with Direct Support Professional (DSP) #1 was conducted on 7/16/12 at 7:25 A.M DSP #1 indicated				bi-monthly thereafter. the Serv	rice	
					Coordinator and Community		
					Services Nurse will review log	8	
					daily. All training forms will be		
	client #2 was on	a pureed diet.			submitted within 48 hours of a	ll	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	COMPL		
11112 12111	or confidence.	15G635		LDING		07/23/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF F	PROVIDER OR SUPPLIER				(NOX ST		
ARC OF	NORTHWEST IND	ANA INC, THE			IN 46403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	training sessions to Staff		DATE
	Δn interview wit	th the group home			Development Department.		
		al Nurse (LPN) was					
		16/12 at 12:45 P.M The					
	LPN indicated cl						
		have nothing by mouth					
		wallow, but her mother					
	•	that diet order, so she					
		strict liquid diet. The					
	•	cated client #2 should not					
	have eaten oatm	eal due to having been					
	diagnosed as being an aspiration risk.						
	An evening obse	ervation was conducted at					
	the group home	on 7/16/12 from 4:45					
	P.M. until 6:45 I	P.M During the					
	observation DSP	#3 prepared the meal					
	which consisted	of baked chicken,					
	macaroni and ch	eese, string beans and					
	•	At 5:30 P.M., DSP #2					
	•	bowl of vanilla pudding					
		15 P.M., DSP #3 placed 3					
	-	elient #2, one cup had					
	_	another had pureed					
		eese and the other had					
	pureed string bea	ans.					
	An intorvious	th DSP #3 was conducted					
	on 7/16/12 at 6:2						
		#2 was on a pureed diet.					
	mulcated chefft #	rz was on a purceu uiet.					
	A review of clien	nt #2's record on 7/17/12					
	at 12:30 P.M. inc	dicated a nutritional					
	assessment, date	d 12/30/11. Client #2's					
					l .		ı

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION 00	(X3) DATE SURVEY  COMPLETED	
ANDILAN	or connection	15G635		LDING		07/23/	
		100000	B. WIN		DDDEGG CHTH CTATE THE CODE	017207	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE	GARY, IN 46403				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		sment indicated she was					
		ith thick it to liquids."					
		Plan" dated 6/21/12					
		w the symptoms of silent					
	` `	ng): watery eyes,					
		nd voice, excessive					
	T	the signs of dysphagia:					
		movement different than					
	· ·	y starting to swallow,					
		king during or after eating					
	_	pocketing food in the					
		Only allowed foods and					
	I -	es, italian ices blended					
		, plain milk shake (with					
	_	t or other additives),					
	_	rained after cooking so					
		presentFoods not					
		eggs, fish, puddings,					
		g of solid or semi-solid					
	I -	p feeding if she begins					
		imer must be under					
	_	inuously while drinking."					
		t Physician's Orders (PO)					
		dicated "soft diet with					
		ll pieces, thin liquids.					
		t "Barium Cookie					
	Swallow" dated						
		hin liquids onlyPatient					
	_	oderate oral and severe					
		hagia characterized by					
	. ^	in liquids to the vocal					
		n of puree observed					
		g the swallow which did					
	not clear from th	e airway. Aspiration of					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G635	(X2) MULTIPLE CO  A. BUILDING  B. WING	ONSTRUCTION 00	CON	TE SURVEY MPLETED 23/2012
	PROVIDER OR SUPPLIER		440 N F	ADDRESS, CITY, STATE, Z KNOX ST IN 46403	IP CODE	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO	ON SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENCY		DATE
	swallow (cough	during and after the response). Aspiration combination of delayed conds)."				
	When asked why diets ordered for don't know." W	17/12 at 11:10 A.M y there were different client #2, she stated "I hen asked which diet should be given, she				
	Nurse (LPN) wa at 12:45 P.M T	th the Licensed Practical as conducted on 7/17/12 The LPN stated "I left a doctor to get clarification should be on."				
	Handling Cases dated 2/15/12 was facility's administ at 6:30 P.M., and protect the generation of the Exploitation of the commediately reparations, neglect or clients per agence.	facility's "Policy for of Neglect and Abuse" as completed at the strative office on 7/17/12 d indicated: "In order to ral welfare of the clients, me] has in effect the with regard to abuse, tion, exploitation of all abuse, neglect and ur clientsStaff will ort any allegations of exploitation of our ty reporting lect is defined as failure to				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G635		(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COMI	PLETED 3/2012	
	PROVIDER OR SUPPLIEF		440 N K	ADDRESS, CITY, STATE, ZIP KNOX ST IN 46403	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	of the client and the placing of a poses a threat to beingseclusion alone in a room	anticipate and remedy client in a situation that his/her health and well by placing an individual or other area from which is not providing adequate aving clients				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	4 DI III	DDIC	00	COMPLE	ETED
		15G635	B. WIN	LDING		07/23/2	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				KNOX ST		
ARC OF	NORTHWEST INDI	ANA INC, THE			IN 46403		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0192	483.430(e)(2) STAFF TRAINING	G PROGRAM ho work with clients,					
	training must focu						
	Based on observa	ation, record review and	W0192 The Community Service Nu		The Community Service Nurse	÷	08/22/2012
	interview, the facility failed for 1 of 2				will re-train the DSP's on following		
	sampled clients (	client #2) by staff not			medication orders and	_	
	•	xills and competency to 1.			documenting daily or as ordered by the doctor on the Medicatio		
	_	cations as prescribed, and			Administration Record. DSPs v		
	2. provide diets as ordered.				also be trained on verify the		
2. provide diets t	is ordered.			medication labels and			
	Findings include:				documentation match 3 times		
	rmanigs include				before administering. To ensur		
	1 4 . 1	1 . 1			further compliance the nurse v visit group home monthly for	/111	
	_	oservation was conducted			three months and periodically		
	• .	ne on 7/16/12 from 6:15			thereafter. 8/28/12Service		
		A.M At 7:45 A.M.,			Coordinator and/or Community	/	
	• •	rofessional (DSP) #2			Services Nurse will retrain all s		
	picked up a bottl	e of nasal spray			for all medical supervision with		
	(Fluticasone Proj	p 50 milligrams spray)			regards to medical and dietary needs for clients. Training forn		
	and sprayed 1 sp	ray in each of client #2's			will be submitted to the Staff	13	
	nostrils. Review	of the bottle indicated			Development Department for		
	client #3's name.	When asked who the			tracking and filing. Staff will		
	nasal spray belor	nged to, DSP #2 stated			document dietary restrictions a	and	
		in the wrong drawer."			food prepared on daily logs. Service Coordinator and/or		
					Community Services Nurse wi	.	
	An interview wit	th the Licensed Practical			review the logs daily.To ensure		
		s conducted on 7/17/12 at			future compliance, Service		
	` ,	ELPN indicated DSP #2			Coordinator and/or Community		
		cked the label three times			Services Nurse will visit the gre	oup	
					home at least weekly for four weeks and then at least		
	to make sure it w	as the right client.			bi-monthly thereafter, the Serv	ice	
					Coordinator and Community		
	_	oservation was conducted			Services Nurse will review logs		
	at the group hom	ne on 7/16/12 from 6:15			daily. All training forms will be		

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Event ID: V8G911

Facility ID: 001211

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G635		00	(X3) DATE SURVEY COMPLETED 07/23/2012
	ROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	440 N F	ADDRESS, CITY, STATE, ZIP CODE  KNOX ST IN 46403	1
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	A.M. until 8:10 A.M During the observation Direct Support Professional (DSP) #1 prepared oatmeal, waffles and sausage patties. At 7:20 A.M., client #2 was observed eating a bowl of oatmeal of regular consistency. At 7:25 A.M., client #2 started coughing repeatedly, had tears in her eyes and saliva coming out of her mouth. DSP #1 walked from the kitchen and placed a cup of water on the table and client #2 began drinking the water. Client #2 repeatedly coughed for about 10 minutes.  An interview with Direct Support Professional (DSP) #1 was conducted on 7/16/12 at 7:25 A.M DSP #1 indicated client #2 was on a pureed diet.  An interview with the group home Licensed Practical Nurse (LPN) was conducted on 7/16/12 at 12:45 P.M The LPN indicated client #2 was recommended to have nothing by mouth per her cookie swallow, but her mother refused to allow that diet order, so she was placed on a strict liquid diet. The LPN further indicated client #2 should not have eaten oatmeal due to having been diagnosed as being an aspiration risk.  An evening observation was conducted at the group home on 7/16/12 from 4:45 P.M. until 6:45 P.M During the		submitted within 48 hours of a training sessions to Staff Development Department.	

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Event ID: V8G911

Facility ID: 001211

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G635		LDING	NSTRUCTION 00	COMI	E SURVEY PLETED 3/2012
	PROVIDER OR SUPPLIER		<u> </u>	440 N K	DDRESS, CITY, STATE, ZIP CO	DE	
	NORTHWEST INDI			<u> </u>	IN 46403		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	which consisted macaroni and ch canned peaches. gave client #2 a for snack. At 6: cups in front of cups in formal cup	th DSP #3 was conducted 20 P.M DSP #3 #2 was on a pureed diet.  Int #2's record on 7/17/12 dicated a nutritional d 12/30/11. Client #2's sment indicated she was with thick it to liquids." Plan" dated 6/21/12 y allowed foods and tes, italian ices blended at, plain milk shake (with at or other additives), rained after cooking so presentFoods not teggs, fish, puddings, g of solid or semi-solid					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE : COMPL		
		15G635	A. BUI B. WIN	LDING		07/23/	
			B. WIIV		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	ROVIDER OR SUPPLIER			440 N K	NOX ST		
ARC OF	NORTHWEST INDI	IANA INC, THE		GARY, I	IN 46403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		: "Current diet: Thin		1710			DITTE
	liquids onlyPat						
	_	ral and severe pharyngeal					
	dysphagia charac	cterized by penetration of					
	thin liquids to th	e vocal cords, penetration					
	_	d before and during the					
		lid not clear from the					
	-	on of puree observed					
	_	the swallow (cough ration resulted from a					
		delayed swallow (2-5					
		ocumentation was					
	, , , , , , , , , , , , , , , , , , ,	view to indicate all staff					
	working with cli	ent #2 were trained on					
	her prescribed di	iet.					
	9-3-3(a)						

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Event ID: V8G911

Facility ID: 001211

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G635	B. WIN			07/23/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				(NOX ST		
ARC OF	NORTHWEST INDI	ANA INC, THE			IN 46403		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0248	483.440(c)(7) INDIVIDUAL PRO A copy of each cl be made available including staff of o with the client, an the client is a min Based on record facility failed to Support Plans (IS residing at the gr and #3), available worked at the fact Findings include  A facility owned was conducted o A.M. until 11:55 observation clier recliner with a sl body.  Client #1, #2 and reviewed on 7/16 review of client is most current ISP for staff who wo of client #2's rec- current ISP dated client #3's record ISP dated 1/24/1 documentation we to indicate client	DGRAM PLAN ient's individual plan must e to all relevant staff, other agencies who work d to the client, parents (if or) or legal guardian. review and interview, the have updated Individual SP) for 3 of 4 clients roup home (clients #1, #2 e for all staff who cility owned day program.  I day program observation in 7/16/12 from 10:20 A.M During the entire int #3 was laying in a neet covering her entire  If #3's records were 6/12 at 10:50 A.M A #1's record indicated a dated 8/19/10 available riked with her. A review ord indicated a most d 5/5/10. A review of a indicated a most current	Wo		Current ISPs have been sent to both the home and the Day Services Center. To ensure fut compliance, a new copy of the ISP will be sent to the home at the Day Services Center any to a change is made or an annual meeting is held. 8/28/12The pl were updated by 8/28/12 and distributed to the day program and the group home by the assigned Community Services Nurse. To ensure future compliance a tracking system monitor the distribution of the replans will be developed and maintained by the Lead Service Coordinator.	ture  nd  me I  ans	08/22/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G635	B. WIN	G		07/23/	2012
NAME OF B	DOLUMEN OF GLIPPI HER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L		440 N K	NOX ST		
	NORTHWEST INDI	IANA INC, THE		GARY,	IN 46403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	with the clients a	at the day program.					
	Interview with d conducted on 7/1 DSP #4 indicated most current ISP the day program  A review of client conducted at the office on 7/17/12 record indicated 6/28/11.  A review of client conducted at the office on 7/17/12 record indicated 7/6/11.  A review of client conducted at the office on 7/17/12 record indicated 7/6/11.  A review of client conducted at the office on 7/17/12 record indicated 6/22/12.  An interview with Coordinator (SC 7/17/12 at 12:50 the group home states.	ay program DSP #4 was 16/12 at 11:20 A.M d client #1, #2 and #3's es were not available for staff.  Int #1's record was facility's administrative 2 at 11:30 A.M The a most current ISP dated  Int #2's record was facility's administrative 2 at 12:00 P.M The a most current ISP dated  Int #3's record was facility's administrative 2 at 1:15 P.M The a most current ISP dated					
	9-3-4(a)						

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G635	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COMF 07/23	E SURVEY PLETED 3/2012		
	PROVIDER OR SUPPLIE NORTHWEST INC	DIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE  440 N KNOX ST  GARY, IN 46403					
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES  NCY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TI DEFICIENCY	CORRECTION IN SHOULD BE HE APPROPRIATE ()	(X5) COMPLETION DATE		

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Event ID: V8G911

Facility ID: 001211

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G635			LDING	ONSTRUCTION  00	(X3) DATE : COMPL <b>07/23</b> /	ETED	
	PROVIDER OR SUPPLIER		B. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE KNOX ST IN 46403		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
W0249	formulated a clier each client must in treatment prograr interventions and number and frequachievement of the individual program interview, the factories written objective opportunity for 2 residing at the graph observation clier porch with no act match money, diperson, repeat we communication by wheelchair with not identify picture clean table or pure matching. At 7:4 Professional (DS client #1's medical to her. Client #1	terdisciplinary team has noted in consisting of needed services in sufficient services identified in gram plan.  ation, record review, and collity failed to implement seduring times of 2 of 2 sampled clients roup home (clients #1 and compared to the c	W0	249	The Service Coordinator will retrain DSPs on implementation of objectives and document training. 8/22/12 To ensure future compliance, Service Coordinator will obser implementation of the program objectives at least monthly thereafter.	the ve	08/22/2012

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE ( COMPL	
11112 12111	or confidence.	15G635		LDING		07/23/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				NOX ST		
ARC OF	NORTHWEST IND	ANA INC, THE		GARY,	IN 46403		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		administered them.		TAG	DEFICIENCY)		DATE
		administered them.					
	route of the med	•					
	Toute of the filed	ication.					
	An evening obse	ervation was conducted at					
	_	on 7/16/12 from 4:45					
	P.M. until 6:45 I	P.M During the					
	observation clier	nt #1 stood on the back					
	•	tivity. Client #1 did not					
		al phone and request					
person, repeat words and sign or use a							
	communication book. Client #2 sat in her						
		no activity. Client #2 did					
		ares, identify money,					
	clean table or pu	t away items by					
	matching.						
	A review of clien	nt #1's record was					
	conducted at the	facility's administrative					
	office on 7/17/12	2 at 11:30 A.M The					
	record indicated	a most current ISP dated					
	6/28/11 which in	idicated: "Will repeat					
	_	initiatedUse her					
		book to express her wants					
	and needs and ut	C					
		bhone and request					
	personmatchin medication.".	g moneylearn					
	medication.".						
	A review of clies	nt #2's record was					
		facility's administrative					
		2 at 12:00 P.M The					
		a most current ISP dated					
		licated: "Will identify					

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G635		A. BUILDING B. WING	COMPLETED 07/23/2012	
	PROVIDER OR SUPPLIER		440 N K	ADDRESS, CITY, STATE, ZIP CODE KNOX ST IN 46403	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	picturesIdentif tableLearn med	-			
	interviewed on 7 The SC stated cl implemented "du opportunity." The clients #1 and #2 provided with m	ne SC further indicated 2 should have been			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		00	COMPLETED		
		15G635	A. BUILDING		07/23/2012		
			B. WING	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	ER	440 N KNOX ST				
ARC OF	NORTHWEST INI	DIANA INC. THE	GARY,				
		·		1	(7/5)		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION		
TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE		
W0260	+	or esc identiff find information)	IAG		DATE		
VVU260	483.440(f)(2)	NITORING & CHANGE					
		y, the individual program plan					
		l, as appropriate, repeating					
	the process set forth in paragraph (c) of this section.						
	Based on recor	d review and interview for	W0260	ISP will be reviewed and ren			
	1 of 2 sampled	clients (client #1), the		within 365 days of the previo	us		
	Service Coordi	nator (QMRP) failed to		ISP. To ensure future compliance, Service Coordin	octor		
	revise their Ind	revise their Individual Support Plan (ISP)		will verify updated paperwork			
	within 365 days of the previous ISP.			at the group home and Day			
		1		Services. 8/28/12The IPPs w	vere .		
	Findings include	le:		updated by 8/28/12 and			
	i mamgs merae			distributed to the day program	m		
	A ravious of ali	ent #1's record was		and the group home by the			
				assigned Individual Program Coordinator. To ensure futur			
		e facility's administrative		compliance a tracking syster			
		12 at 11:30 A.M Client		monitor the distribution of the			
		icated a most recent ISP		will be developed and mainta	ained		
		There was no evidence of		by the Lead Service Coordin	ator.		
	a more recent I	SP.					
	The SC was int	terviewed on 7/17/12 at					
	12:50 P.M., and	d indicated client #1's ISP					
	had not been re	evised within 365 days of					
	the previous IS	-					
	pro-104616						
	9-3-4(a)						
	)-3- <del>1</del> (a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G635	B. WIN			07/23/	2012
			В. WПV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				(NOX ST		
ARC OF	NORTHWEST INDI	ANA INC. THE			IN 46403		
						1	77.5
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY		DATE
W0268	483.450(a)(1)(i) CONDUCT TOW	APD CLIENT					
		d procedures must					
		rth, development and					
	independence of	the client.					
		ation and interview, the	W0:	268	DSP will be retrained to provid	е	08/22/2012
	facility failed for	1 of 4 clients residing at			appropriate levels of		
	the group home (	(client #4), to promote			support/assistance for persona		
		ot ensuring she was			hygiene needs, using the least intrusive measures. In order to		
	groomed.				ensure future compliance, the	•	
	8				Service Coordinator will observe care during meals and at randor		
	Findings include						
					times, bi-monthly for three		
					months and at least monthly		
	_	vation was conducted at			thereafter.		
	the group home	on 7/16/12 from 6:15					
	A.M. until 8:10 A	A.M During the entire					
	observation clien	nt #4 was observed to					
	have her hair not	combed.					
	A facility owned	day program observation					
		n 7/16/12 from 10:10					
		A.M During the entire					
		nt #4 was observed to					
	have her hair not	combed.					
	_	rvation was conducted at					
	the group home	on 7/16/12 from 4:45					
	P.M. until 6:45 F	P.M. During the entire					
		nt #4 was observed to					
	have her hair not	combed.					
	An interview wit	th the Service					
		) was conducted on					
	` '	<b>,</b>					
		P.M The SC indicated					
	the group home	Direct Support					

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	COMPLETED 07/23/2012
STREET ADDRESS, CITY, STATE, ZIP CODE 440 N KNOX ST GARY, IN 46403	
ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
CROSS-REFERENCED TO THE APPROPR	IATE
	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	LDING	00	COMPLETE	D
		15G635	A. BUII B. WIN			07/23/201	2
			D. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.			KNOX ST		
ARC OF	NORTHWEST IND	IANA INC, THE			IN 46403		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	OMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
W0331	483.460(c) NURSING SERV	ICES					
		provide clients with nursing					
		dance with their needs.					
			W0	331	Client #2 had a cookie swallow	v   08	3/22/2012
	Based on observ	ation, record review and			done on 7/26/12. The results		
		cility failed for 1 of 2			indicated client was to have		
	-	(client #2) by nursing			nothing by mouth due to choki		
	-	uring she received the			risk. A PEG tube was placed of	n	
		•			8/5/12. Community Services  Nurse will train DSPs on		
	proper diet per n	er assessed medical need.			necessary use and care of the		
					PEG tube. To ensure future		
	Findings include	:			compliance, Community Servi	ces	
					Nurse will make a mealtime vi	sit	
	A morning obser	rvation was conducted at			monthly for 3 months and		
	the group home	on 7/16/12 from 6:15			quarterly thereafter. 8/28/12Service Coordinator		
	A.M. until 8:10	A.M During the			and/or Community Services		
	observation Dire	ect Support Professional			Nurse will retrain all staff for a	ı	
		ed oatmeal, waffles and			medical supervision with regar	ds	
	. , .	At 7:20 A.M., client #2			to medical and dietary needs f	or	
		vl of oatmeal of regular			clients. Training forms will be		
	_	7:25 A.M., client #2			submitted to the Staff Development Department for		
	_	repeatedly, had tears in			tracking and filing. Staff will		
		va coming out of her			document dietary restrictions	and	
	_	· ·			food prepared on daily logs.		
		walked from the kitchen			Service Coordinator and/or		
		of water on the table and			Community Services Nurse wi		
	_	drinking the water. Client			review the logs daily.To ensur future compliance, Service	e	
	1 2	ughed for about 10			Coordinator and/or Communit	,	
	minutes.				Services Nurse will visit the gr		
					home at least weekly for four	.	
	An interview wi	th Direct Support			weeks and then at least		
	Professional (DS	SP) #1 was conducted on			bi-monthly thereafter, the Serv	rice	
	,	A.M DSP #1 indicated			Coordinator and Community	_	
	client #2 was on	a pureed diet.			Services Nurse will review log daily. All training forms will be	<b>`</b>	
		1			submitted within 48 hours of a	ıı	
	An interview wit	th the group home			training sessions to Staff		
		9-0 or mornio	- 1		į .	I	

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Event ID: V8G911

Facility ID: 001211

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G635	B. WIN			07/23/2012
NAME OF I	DROLUBER OR GURRU IEE			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER	C		440 N K	(NOX ST	
	NORTHWEST IND	·			IN 46403	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
TAG		REGULATORY OR LSC IDENTIFYING INFORMATION)		IAG	•	DATE
		cal Nurse (LPN) was			Development Department.	
		16/12 at 12:45 P.M The				
	LPN indicated c					
		have nothing by mouth				
	-	wallow, but her mother				
	refused to allow	that diet order, so she				
	was placed on a	strict liquid diet. The				
	LPN further indi	icated client #2 should not				
	have eaten oatm	eal due to having been				
		ng an aspiration risk.				
	An evening obse	ervation was conducted at				
	the group home	on 7/16/12 from 4:45				
	P.M. until 6:45 I	P.M During the				
	observation DSF	P #3 prepared the meal				
	which consisted	of baked chicken,				
		eese, string beans and				
		At 5:30 P.M., DSP #2				
		bowl of vanilla pudding				
	_	15 P.M., DSP #3 placed 3				
		client #2, one cup had				
	•	another had pureed				
	_	eese and the other had				
	pureed string bea	ans.				
	An interview wi	th DSP #3 was conducted				
	on 7/16/12 at 6:2	20 P.M DSP #3				
	indicated client	#2 was on a pureed diet.				
		•				
	A review of clie	nt #2's record on 7/17/12				
	at 12:30 P.M. in	dicated a nutritional				
	assessment, date	ed 12/30/11. Client #2's				
	nutritional assess	sment indicated she was				
	on an "soft diet v	with thick it to liquids."				

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G635		A. BUI	LDING	NSTRUCTION  00	(X3) DATE COMPI 07/23	LETED
		130033	B. WIN		PRESIDENCE CONTROL CON	01723	72012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	ANA INC, THE			IN 46403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	J 1 C	Plan" dated 6/21/12 w the symptoms of silent					
		ing): watery eyes,					
	• `	and voice, excessive					
		the signs of dysphagia:					
	_	movement different than					
		y starting to swallow,					
	,	king during or after eating					
		pocketing food in the					
	•	Only allowed foods and					
		es, italian ices blended					
	_	x, plain milk shake (with					
	-	t or other additives),					
	-	rained after cooking so					
	•	presentFoods not					
	allowed: Meat,	eggs, fish, puddings,					
	bread or anythin	g of solid or semi-solid					
	consistencySto	p feeding if she begins					
	coughingconsu	ımer must be under					
	supervision cont	inuously while drinking."					
	The most curren	t Physician's Orders (PO)					
	dated 3/29/12 in	dicated "soft diet with					
	meats cut in sma	ll pieces, thin liquids.					
		t "Barium Cookie					
		7/9/10 indicated:					
		hin liquids onlyPatient					
	*	oderate oral and severe					
		hagia characterized by					
	_	in liquids to the vocal					
	-	n of puree observed					
		g the swallow which did					
		e airway. Aspiration of					
	-	luring and after the					
	swallow (cough	response). Aspiration					

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PRINTED: 09/07/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G635		00		
	PROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE	440 N K	ADDRESS, CITY, STATE, ZIP KNOX ST IN 46403	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	resulted from a combination of delayed swallow (2-5 seconds)."				
	An interview with the Licensed Practical Nurse (LPN) was conducted on 7/17/12 at 11:10 A.M The LPN stated "I left a message for the doctor to get clarification on what diet she should be on."  9-3-6(a)				

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Event ID: V8G911

Facility ID: 001211

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING 00			ETED
		15G635	B. WIN			07/23/	2012
NAME OF D	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER			440 N K	(NOX ST		
	NORTHWEST INDI			GARY,	IN 46403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG W0369		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
VV0309	483.460(k)(2) DRUG ADMINIST	TRATION					
		rug administration must					
		ugs, including those that					
	are self-administe without error.	ered, are administered					
	without error.		W <sub>0</sub>	360	The Community Service Nurse	<u>.</u>	08/22/2012
			***	307	will re-train the DSP's on follow		00/22/2012
					medication orders and	Ü	
	Based on observ	ation and interview for 1			documenting daily or as ordered		
	of 11 medication	as administered to 1 of 2			by the doctor on the Medicatio Administration Record. DSPs v		
	sampled clients (	(client #2), the facility			also be trained on verify the		
	failed to ensure t	the client received all			medication labels and		
	medications with	nout error.			documentation match 3 times before administering. 8/22/12		
					To ensure further compliance	the	
	Findings include				nurse will visit group home		
	1 manigs merade	•			monthly for three months and quarterly thereafter.		
	A morning obser	vation was conducted at			1		
		on 7/16/12 from 6:15					
		A.M At 7:45 A.M.,					
		rofessional (DSP) #2					
	picked up a bottl	` ´					
		p 50 milligrams for					
		rayed 1 spray in each of					
		ls. Review of the bottle					
		#3's name. When asked					
	_	ray belonged to, DSP #2					
	stated "Someone	put it in the wrong					
	drawer."						
		d was reviewed on					
	7/16/12 at 7:55 A	A.M. Review of the 7/12					

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AND PLAN	D PLAN OF CORRECTION  IDENTIFICATION NUMBER:  15G635  A. BUILDING B. WING		00	COMPLETED 07/23/2012			
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER		440 N KNOX ST				
ARC OF	NORTHWEST INDI	ANA INC, THE		GARY, I	IN 46403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
		inistration Record					
	(MAR) indicated	l client #2 should receive					
		50 mg nasal spray 1					
	spray each nostri						
	1 3						
	An interview wit	h the Licensed Practical					
	Nurse (LPN) was	s conducted on 7/17/12 at					
	12:35 P.M The	LPN indicated DSP #2					
	should have chec	eked the label three times					
	to make sure it w	vas the right client.					
	9-3-6(a)						
	9-3-0(a)						

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		15G635	A. BUII B. WIN			07/23/	2012
			b. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				(NOX ST		
ARC OF	NORTHWEST INDI	ANA INC, THE			IN 46403		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0460	483.480(a)(1) FOOD AND NUTE Each client must well-balanced die specially-prescrib Based on observer record review for (client #2), the fastaff followed client die staff followed client was included.  A morning observer the group home of A.M. until 8:10 A observation Direct (DSP) #1 prepares ausage patties. A was eating a bown consistency. At started coughing her eyes and sali mouth. DSP #1 and placed a cup client #2 began of #2 repeatedly comminutes.  An interview with Professional (DSP 7/16/12 at 7:25 A client #2 was on	RITION SERVICES receive a nourishing, at including modified and led diets. ation, interview and r 1 of 2 sampled clients recility failed to assure lient's prescribed diet  revation was conducted at on 7/16/12 from 6:15 A.M During the lect Support Professional led oatmeal, waffles and At 7:20 A.M., client #2 repeatedly, had tears in va coming out of her walked from the kitchen of water on the table and drinking the water. Client ughed for about 10  th Direct Support SP) #1 was conducted on A.M DSP #1 indicated	Wo		Client #2 had a cookie swallow done on 7/26/12. The results indicated client was to have nothing by mouth due to choki risk. A PEG tube was placed of 8/5/12. Community Services Nurse will train DSPs on necessary use and care of the PEG tube.  To ensure future compliance, Community Services Nurse will make a mealtime visit monthly 3 months and quarterly therea	ng on II for	08/22/2012
		<b>C</b> 1	1				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G635	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 23/2012
	PROVIDER OR SUPPLIER		STREET A 440 N K	ADDRESS, CITY, STATE, ZIP ( KNOX ST IN 46403	CODE	
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION
TAG		al Nurse (LPN) was	TAG	DEFICIENCY)	74 711071111112	DATE
	conducted on 7/3	16/12 at 12:45 P.M The				
	LPN indicated correcommended to	have nothing by mouth				
	-	wallow, but her mother that diet order, so she				
	was placed on a	strict liquid diet. The				
		cated client #2 should not eal due to having been				
	diagnosed as bei	ng an aspiration risk.				
	_	ervation was conducted at on 7/16/12 from 4:45				
	P.M. until 6:45 I	P.M During the P.M. prepared the meal				
	which consisted	of baked chicken,				
		eese, string beans and At 5:30 P.M., DSP #2				
	gave client #2 a	bowl of vanilla pudding 15 P.M., DSP #3 placed 3				
	cups in front of	client #2, one cup had				
		another had pureed eese and the other had				
	pureed string bea	ans.				
		th DSP #3 was conducted 20 P.M DSP #3				
		#2 was on a pureed diet.				
		nt #2's record on 7/17/12				
		dicated a nutritional d 12/30/11. Client #2's				
		sment indicated she was with thick it to liquids."				

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE S COMPL	
MOLLAN	OI CORRECTION	15G635		LDING		07/23/2012	
			B. WIN		DDDEGG CITY OTLTE CITY CODE	317237	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			IN 46403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)				
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE
		Plan" dated 6/21/12					
		allowed foods and					
		es, italian ices blended					
	-	x, plain milk shake (with					
	_	t or other additives),					
	_	rained after cooking so					
		presentFoods not					
		eggs, fish, puddings,					
	-	g of solid or semi-solid					
	consistency." Th						
		ers (PO) dated 3/29/12					
		iet with meats cut in					
		n liquids. The most					
		Cookie Swallow" dated					
		"Current diet: Thin					
	liquids onlyPat	-					
		ral and severe pharyngeal					
		cterized by penetration of					
	-	e vocal cords, penetration					
	•	d before and during the					
		lid not clear from the					
		on of puree observed					
	_	the swallow (cough					
		ration resulted from a					
		lelayed swallow (2-5					
	seconds)."						
	0.2.9(a)						
	9-3-8(a)						

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		15G635	B. WING		07/23/2012		
NAME OF F	PROVIDER OR SUPPLIEI	3		ADDRESS, CITY, STATE, ZIP CODE			
			440 N KNOX ST				
ARC OF	NORTHWEST IND	IANA INC, THE	GARY,	IN 46403			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
				l .			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII DIDIG	00	COMPLETED	
		15G635	A. BUILDING		07/23/2012	
			B. WING	ADDRESS CITY STATE ZIR CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
4D0 0E	NODEL IMPORTANT	NAMA INO THE	440 N KNOX ST			
ARC OF	NORTHWEST IND	DIANA INC, THE	GARY,	IN 46403		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
W0484	chairs, eating ute to meet the dever client.  Based on observation facility failed for #2, #3 and #4) It provide condimuses findings included in the group home. A.M. until 8:10 observation Dir (DSP) #1 preparasusage patties. Substitute, butte or ketchup was #2, #3 and #4's An interview we Coordinator (SC 7/17/12 at 12:50).	requip areas with tables, ensils, and dishes designed elopmental needs of each vation and interview, the or 4 of 4 clients (clients #1, iving in the group home to ents at the dining table.  e:  ervation was conducted at on 7/16/12 from 6:15  A.M During the ect Support Professional red oatmeal, waffles and No sugar/sugar er, syrup, milk, cinnamon available for clients #1, use.  ith the Service  C) was conducted on D P.M The SC indicated uld be put on the table for	W0484	The Service Coordinator will re-train the DSP to have condiments available to all cli during all meal times. To ens future compliance the Service Coordinator will make random visits to monitor the complete dining experience monthly for three months and quarterly thereafter.	ure : 1	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A RIII	BUILDING 00		COMPLETED		
15G635		15G635	B. WIN			07/23/2012		
					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER	R.		440 N KNOX ST				
ARC OF NORTHWEST INDIANA INC, THE				GARY, IN 46403				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		+	TAG	DEFICIENCY)		DATE	
W0488	483.480(d)(4)							
	DINING AREAS AND SERVICE							
	The facility must assure that each client eats in a manner consistent with his or her							
		developmental level.						
	Based on observ	Based on observation, record review, and		488	The Service Coordinator will		08/22/2012	
	interview, the fa	cility failed to assure 4 of			retrain DSP to have clients			
	4 sampled client	s living in the group			participate in the dining	vir.		
	home (clients #1, #2, #3, and #4) participated in family style dining.				experience to the extent of the assessed capabilities. To ensu			
					future compliance, the Service			
					Coordinator will make random			
	Findings include	<b>:</b> :			visits to monitor participation			
					monthly for three months and	ıd		
	A morning observation was conducted at				quarterly thereafter.			
	_	on 7/16/12 from 6:15						
	• •	A.M During the						
		· ·						
	observation Direct Support Professional							
	(DSP) #1 prepared oatmeal, waffles and							
	sausage patties. While DSP #1 prepared the morning meal clients #1, #2, #3 and #4 sat in the living room with no activity. At 7:15 A.M., DSP #1 walked around the table, set each client's prepared bowl and							
	-	e. Clients #1, #2, #3 and						
	#4 did not assist in meal preparation and							
	did not serve the	emselves. Clients #1, #2,						
	#3 and #4 ate the	eir meal independently.						
	An evening obse	ervation was conducted at						
	the group home	on 7/16/12 from 4:45						
	P.M. until 6:45 I							
		9 #3 prepared the meal						
		of baked chicken,						
		eese, string beans and						
	canned peaches, while clients #1, #2, #3							
	camica peaches,	willie circles $\pi 1$ , $\pi 2$ , $\pi 3$						

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	OF CORRECTION  IDENTIFICATION NUMBER:  15G635	A. BUILDING  B. WING		COMP.	COMPLETED 07/23/2012		
	PROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE  440 N KNOX ST  GARY, IN 46403					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
	and #4 sat with no activity. Clients #1, #2, #3 and #4 ate their meal independently.						
	An interview with the Service Coordinator (SC) was conducted on 7/17/12 at 12:50 P.M The SC indicated clients #1, #2, #3, and #4 were developmentally capable of participating in the family dining process.  9-3-8(a)						

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